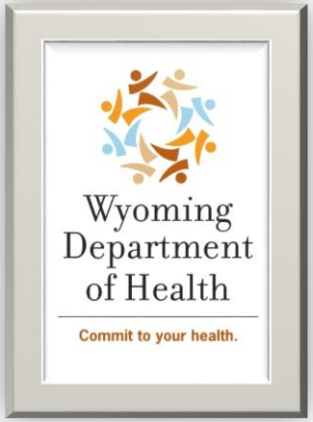
MEDICAID



What is Medicaid?

- Medicaid is jointly funded by federal and state governments, and provides health coverage for selected categories of individuals with low income and limited resources.

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Medicaid Coverage Groups & Categories

- Wyoming covers many eligibility groups within three major categories:
  - Family and Children
  - Medicare Savings Programs
  - Aged, Blind, or Disabled

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Handout

Who is Eligible for Wyoming Medicaid?

Wyoming Department of Health

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Medicaid Applications

- The Department of Health handles all Medicaid applications within two business units in Cheyenne:
  - WDH - Customer Service Center
  - WDH - Long term Care Unit

Wyoming Department of Health

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WDH - Customer Service Center

The Customer Service Center processes applications and determines eligibility for the following programs:

- Family and Children (MAGI)
- Employed Individuals with Disabilities (EID)
- Supplemental Security Income (SSI)
- Medicare Savings Program (MSP)
- Breast and Cervical Cancer (BCC)

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WDH - Customer Service Center

- **Mail or bring Medicaid application to:**
  WDH - Customer Service Center
  3001 E. Pershing Blvd, Suite 125
  Cheyenne, WY 82009

- **Fax To:**
  WDH - Customer Service Center 1-855-329-5205

- **Apply by phone:**
  WDH - Customer Service Center 1-855-294-2127

- **Email to:**
  wesapplications@wyo.gov

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WDH – Long Term Care Unit

The Long Term Care Unit processes Medicaid applications for the following programs:

- Nursing Homes
- Home and Community Based Services (HCBS) Waivers
- Inpatient Hospital Care
- Hospice

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WDH - Long Term Care Unit:

- **Mail or bring paper application to:**
  122 West 25th St
  4th Floor West
  Cheyenne, WY 82002

- **Fax to:**
  1-307-777-8399

- **Apply by phone:**
  1-855-203-2936

- **Email to:**
  ltcunit@wyo.gov

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Application Processing Timeframes

- Applications are entered in the Wyoming Eligibility System (WES) and distributed to the appropriate Financial Eligibility Specialist. The specialist will:
  - Screen application;
  - Complete a phone interview with the applicant or authorized representative; and
  - Send a notice requesting verification, if needed.
- Application Processing Timeframes:
  - Applicant should send verification for all resources marked “yes” in Appendix D of the application to speed up the processing timeframe.
    - 45 days when verifications are included
    - 60 days when waiting for verification
    - 90 days when a disability determination is pending.

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Reopening Timeframes

- Reason a case may be closed or denied:
  - Failure to provide all requested verifications
  - Failure to complete/submit renewal form
  - Other eligibility factors such as over income or over resources

- Reopening Timeframes:
  - Renewal – 90 days from closure notice
  - New applications – 60 days from denial
  - Must provide all verification and be eligible for case to be reopened

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Renewals

- The renewal form and notice are automatically generated and mailed by the system, at the beginning of the month prior to the renewal due date.
- Closure notice is automatically generated by the system when the renewal is not received (except during the Public Health Emergency (PHE)).
  - Benefits are being continued during the PHE- unless the client passes away, moves out of state, requests closure, substantiated fraud or agency error.
- Processing timeframe for a renewal is 30 days. It may take longer when waiting for verifications.

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Eligibility Requirements
Aged, Blind or Disabled Programs

- **Aged (65 or older), Blind, or Disabled**
  - Inpatient Hospital
  - Community Choices Home & Community Based Waiver
  - Nursing Home
- **Age Limit**
  - Acquired Brain Injury (ABI) - 21 - 64
    - Clients may continue to be eligible, after age 65, if they were active on the waiver before their 65th birthday
  - Children's Mental Health - 4 - 20
  - CCW - 19 or older

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Supplemental Security Income (SSI) Clients

- If the applicant receives SSI:
  - They will need to complete the application for the Community Choice Waiver, https://health.wyo.gov/healthcarefin/hcbs/ccw-participant-services-and-eligibility/ or Supports Waiver, https://health.wyo.gov/healthcarefin/hcbs/dd-participant-services-and-eligibility/.
  - They will not need a financial application as long as they are in current SSI status through the Social Security Office.
  - Please reach out to your Financial Eligibility Specialist to have them check the SSI status if you are unsure.
  - If the applicant receives Social Security Disability Insurance (SSDI), then they **DO** need a financial application.

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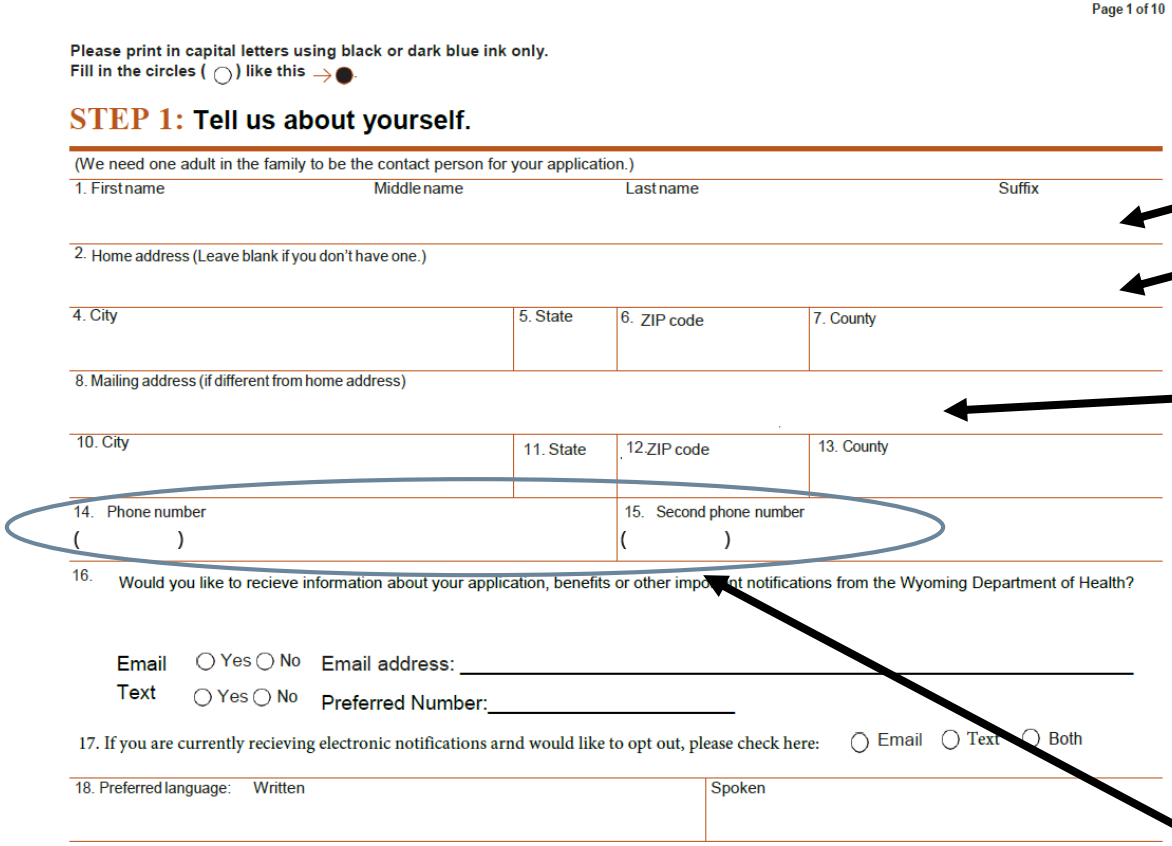
Application Step1

If a child is applying for a program (ex: CMH, Supports, or Comprehensive Waiver) only include the child's information on the form.



Page 1 of 10

Please print in capital letters using black or dark blue ink only.
Fill in the circles (◯) like this → ●.

STEP 1: Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name | Middle name | Last name | Suffix

2. Home address (Leave blank if you don't have one.)

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address)

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) | 15. Second phone number ( )

16. Would you like to recieve information about your application, benefits or other important notifications from the Wyoming Department of Health?

Email ◯ Yes ◯ No Email address: _____

Text ◯ Yes ◯ No Preferred Number: _____

17. If you are currently recieving electronic notifications arnd would like to opt out, please check here: ◯ Email ◯ Text ◯ Both

18. Preferred language: Written | Spoken

Enter **applicant's** information or parent's information for a minor child

The mailing address can be for the person assisting in completing the application.

14: Provide a working phone number for the applicant
15: Can be a representative phone number

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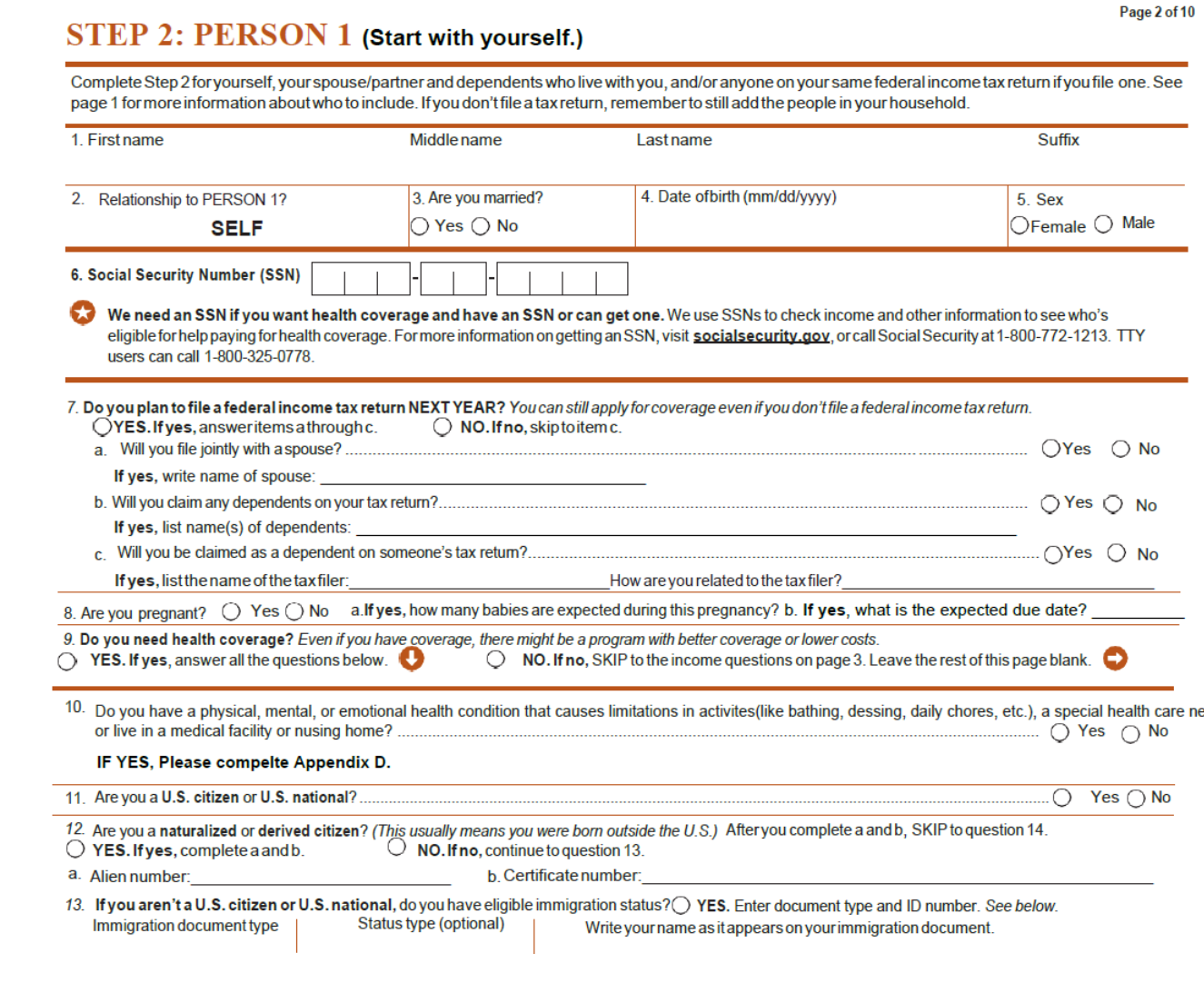
Application Step 2 Person 1



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STEP 2: PERSON 1 (Start with yourself.)

Complete Step 2 for yourself, your spouse/partner and dependents who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add the people in your household.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married?	4. Date of birth (mm/dd/yyyy)	5. Sex
SELF	◯ Yes ◯ No		◯ Female ◯ Male

6. Social Security Number (SSN) ___ - ___ - ____

We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*
◯ **YES. If yes,** answer items a through c. ◯ **NO. If no,** skip to item c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No
If yes, write name of spouse: _____

b. Will you claim any dependents on your tax return? ..... ◯ Yes ◯ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ..... ◯ Yes ◯ No
If yes, list the name of the tax filer: _____ How are you related to the tax filer? _____

8. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? b. **If yes,** what is the expected due date? _____

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*
◯ **YES. If yes,** answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activites(like bathing, dessing, daily chores, etc.), a special health care need, or live in a medical facility or nusing home? ..... ◯ Yes ◯ No
IF YES, Please compelte Appendix D.

11. Are you a **U.S. citizen** or **U.S. national**? ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)* After you complete a and b, SKIP to question 14.
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 13.
a. Alien number: _____ b. Certificate number: _____

13. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See below.*
Immigration document type | Status type (optional) | Write your name as it appears on your immigration document.

Person 1 information is for the **applicant**.

If a child is applying for a program (ex: CMH, Supports, or Comprehensive Waiver) only include the child's information on the application.

If a family is applying for family and children, then the whole family needs to be included in the application.

Wyoming Department of Health

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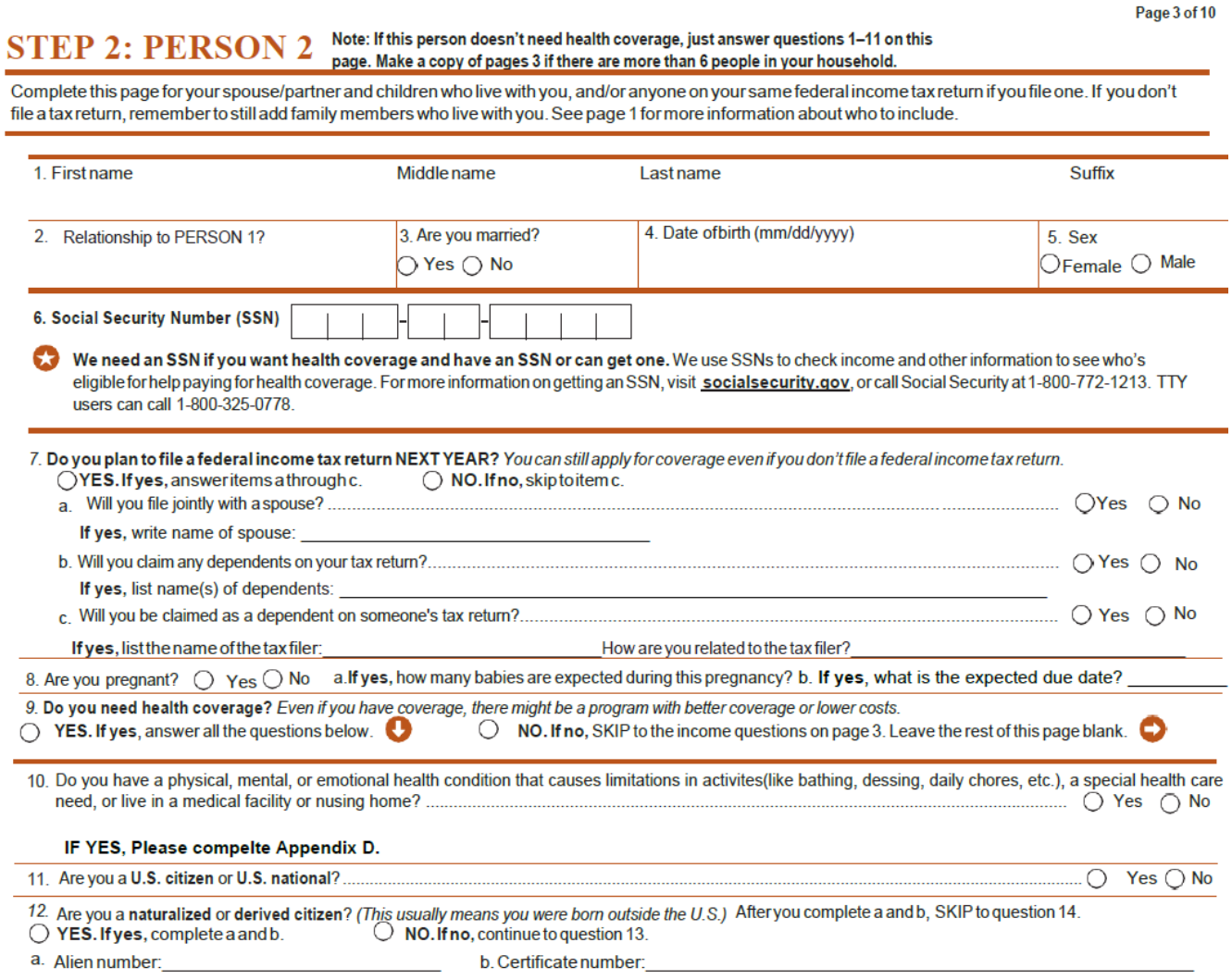
Application Step 2 Person 2 - 6



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STEP 2: PERSON 2 **Note: If this person doesn't need health coverage, just answer questions 1–11 on this page. Make a copy of pages 3 if there are more than 6 people in your household.**

Complete this page for your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. See page 1 for more information about who to include.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married? ◯ Yes ◯ No	4. Date of birth (mm/dd/yyyy)	5. Sex ◯ Female ◯ Male

6. Social Security Number (SSN) ___ - ___ - ____

We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*
◯ **YES. If yes,** answer items a through c. ◯ **NO. If no,** skip to item c.
a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No
If yes, write name of spouse: _____
b. Will you claim any dependents on your tax return? ..... ◯ Yes ◯ No
If yes, list name(s) of dependents: _____
c. Will you be claimed as a dependent on someone's tax return? ..... ◯ Yes ◯ No
If yes, list the name of the tax filer: _____ How are you related to the tax filer? _____

8. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? b. **If yes,** what is the expected due date? _____

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*
◯ **YES. If yes,** answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activites(like bathing, dessing, daily chores, etc.), a special health care need, or live in a medical facility or nusing home? ..... ◯ Yes ◯ No

IF YES, Please compelte Appendix D.

11. Are you a **U.S. citizen** or **U.S. national**? ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)* After you complete a and b, SKIP to question 14.
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 13.
a. Alien number: _____ b. Certificate number: _____

Include other individuals in the household.

Spouse or minor children

Social security number and Date of Birth are <u>required</u> for all individuals applying for coverage.

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Interfaces

- Interfaces and other tools utilized
  - Asset Verification System (AVS)
    - Identifies bank accounts within the 5 year look back period
  - Revenue Information System (RIS)
    - Identifies registered vehicles or vehicles sold within the 5 year look back period
    - Wyoming drivers license or state ID card
  - County Tax Assessors' Websites
    - Identifies property owned by clients
  - Vital Statistics
    - Locates birth certificates on individuals born in Wyoming
  - State On Line Query (SOLQ)
    - Social Security income
    - Medicare Part A/B entitlement/premiums

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Basic Eligibility Requirements For All Programs

Verification is required for the following:

- Social Security Number
- Date of Birth
- Wyoming Residency
- Citizenship
- Identity

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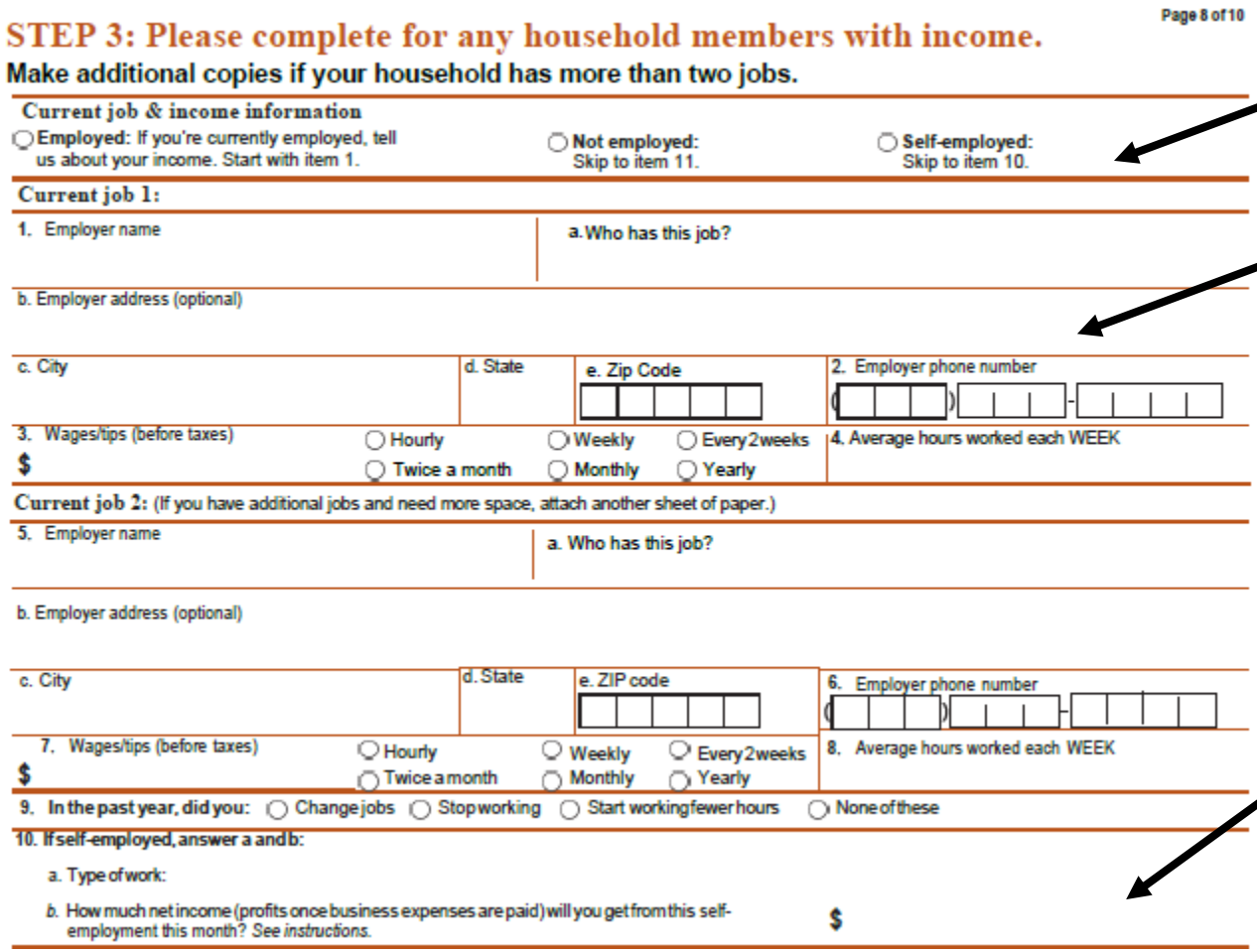
Application Step 3



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STEP 3: Please complete for any household members with income.

Make additional copies if your household has more than two jobs.

Current job & income information

◯ **Employed:** If you're currently employed, tell us about your income. Start with item 1.

◯ **Not employed:** Skip to item 11.

◯ **Self-employed:** Skip to item 10.

Current job 1:

1. Employer name

a. Who has this job?

b. Employer address (optional)

c. City

d. State

e. Zip Code

2. Employer phone number

3. Wages/tips (before taxes)

$

◯ Hourly ◯ Weekly ◯ Every 2 weeks

◯ Twice a month ◯ Monthly ◯ Yearly

4. Average hours worked each WEEK

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper.)

5. Employer name

a. Who has this job?

b. Employer address (optional)

c. City

d. State

e. ZIP code

6. Employer phone number

7. Wages/tips (before taxes)

$

◯ Hourly ◯ Weekly ◯ Every 2 weeks

◯ Twice a month ◯ Monthly ◯ Yearly

8. Average hours worked each WEEK

9. **In the past year, did you:** ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

10. **If self-employed, answer a and b:**

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? *See instructions.* $

Employment status

Employment information

Self employed

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Application Step 3

11. Other income you get this month: Fill in all that apply, and give the amount and how often you get it. Fill in here if none. ◯
NOTE: You don't need to tell us about income from child support, veteran's payments, or Supplemental Security Income (SSI).

◯ Unemployment $ How often? Who?	◯ Alimony received $ How often? Who?
◯ Pension $ How often? Who?	◯ Net farming/fishing $ How often? Who?
◯ Social Security $ How often? Who?	◯ Net rental/royalty $ How often? Who?
◯ Retirement accounts $ How often? Who?	Other income, type: _____ ◯ $ How often? Who?

12. Deductions: Fill in all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include child support that you pay, or a cost already considered in your answer to net self-employment.

◯ Alimony paid $ How often?	◯ Other deductions, type: _____ $ How often?
◯ Student loan interest $ How often?	

13. Complete this question if your income changes during the year, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income this year	Your total income next year (if you think it'll be different)
	◯ Fill in if you think your income will be hard to predict.

NEED HELP WITH YOUR APPLICATION? Visit www.wesystem.wyo.gov, or call us at 1-855-294-2127. Para obtener una copia de este formulario en Español, llame 1-855-294-2127. If you need help in a language other than English, call 1-855-294-2127 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users can call 1-885-329-5204. If applying for Aged, Blind or Disabled programs call 1-855-203-2936 for help.

Include all household income with the exception of a child applying for a waiver program. For a child applying for a waiver program, only include the child's income.

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Income
Aged, Blind or Disabled

- Income Standard - $2,382
  - Inpatient Hospitals
  - HCBS Waivers
  - Nursing Homes
  - Hospice

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Verification Requirements

- Gross Income (Before Taxes)
  - Social Security can be verified by a Financial Eligibility Specialist through SOLQ or by calling Social Security Administration (SSA) office. Applicant may also provide a current award letter.
  - Pension Award Letters- including gross benefit amount and any deductions
  - Wage stubs – most recent of 30 days
  - VA Pension- including a break down of benefits
  - Railroad Pension
  - Unemployment Benefits- Award letter and terms of benefit

Any change of income must be reported to the LTC unit within 10 days

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IRA 401K & Retirement Plans

- If a retirement plan is not annuitized, and any portion can be cashed out at any time, then it may count as both a resource and an income source.
- Make sure to send all documents needed in order for the Financial Eligibility Specialist to determine whether is has been annuitized or has the ability to be cashed out by the applicant.
- **Nonexempt** - Count the cash value stated by the employer, company, or financial institution when the applicant has the authority to withdraw the funds.
- **Exempt** pension/retirement funds not available or belonging to an ineligible spouse.

Annuitized defined: The client exchanges a policy's accumulated cash value for payment plan.

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Irrevocable Income Trust

- Applicants for the following programs can submit an irrevocable income trust if their gross monthly income is over the $2,382 per month
  - Community Choices Waiver
  - Nursing Home
  - Comprehensive Waiver
  - Support Waiver

Note: If the applicant has a spouse, then only the gross income amount for the applicant is added together in order to determine if an income trust is needed. If the spouse is the person over income then the applicant would not need the income trust.

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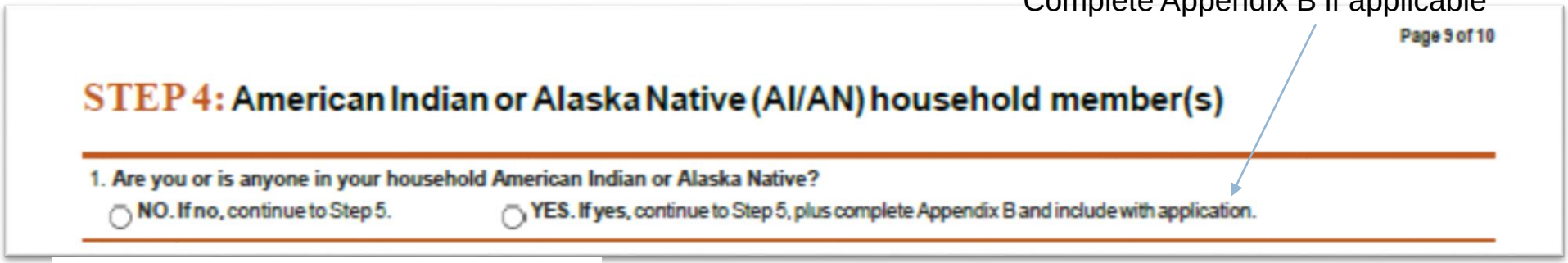
Application Step 4

Complete Appendix B if applicable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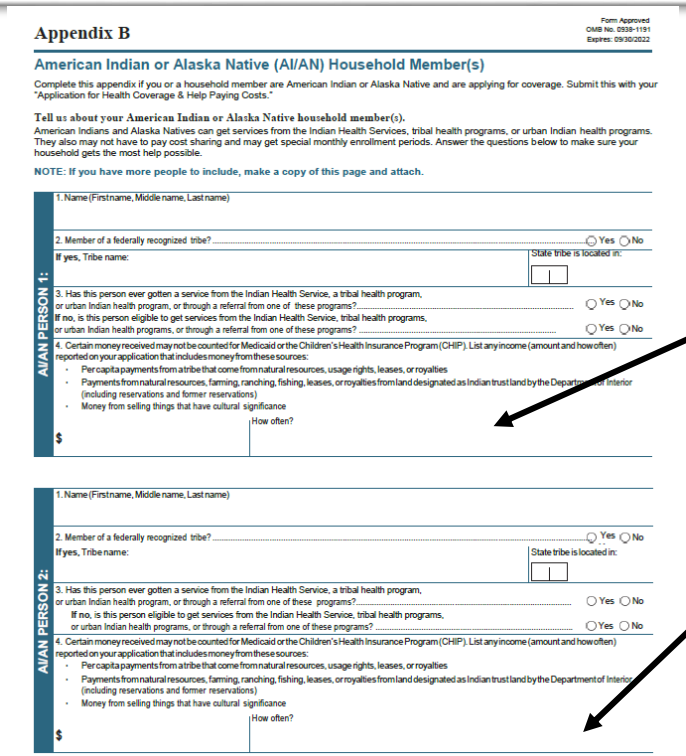
STEP 4: American Indian or Alaska Native (AI/AN) household member(s)

1. Are you or is anyone in your household American Indian or Alaska Native?

◯ NO. If no, continue to Step 5. ◯ YES. If yes, continue to Step 5, plus complete Appendix B and include with application.


Appendix B

Form Approved
OMB No. 0938-1191
Expires: 09/30/2022

American Indian or Alaska Native (AI/AN) Household Member(s)

Complete this appendix if you or a household member are American Indian or Alaska Native and are applying for coverage. Submit this with your "Application for Health Coverage & Help Paying Costs."

Tell us about your American Indian or Alaska Native household member(s).
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the questions below to make sure your household gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1:

1. Name (Firstname, Middle name, Last name)

2. Member of a federally recognized tribe? ◯ Yes ◯ No
If yes, Tribe name: | State tribe is located in:

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ◯ Yes ◯ No
If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ◯ Yes ◯ No

4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:
- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

$ | How often?

AI/AN PERSON 2:

1. Name (Firstname, Middle name, Last name)

2. Member of a federally recognized tribe? ◯ Yes ◯ No
If yes, Tribe name: | State tribe is located in:

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ◯ Yes ◯ No
If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ◯ Yes ◯ No

4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:
- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

$ | How often?

If applicant receives per capita payments please include payment history.

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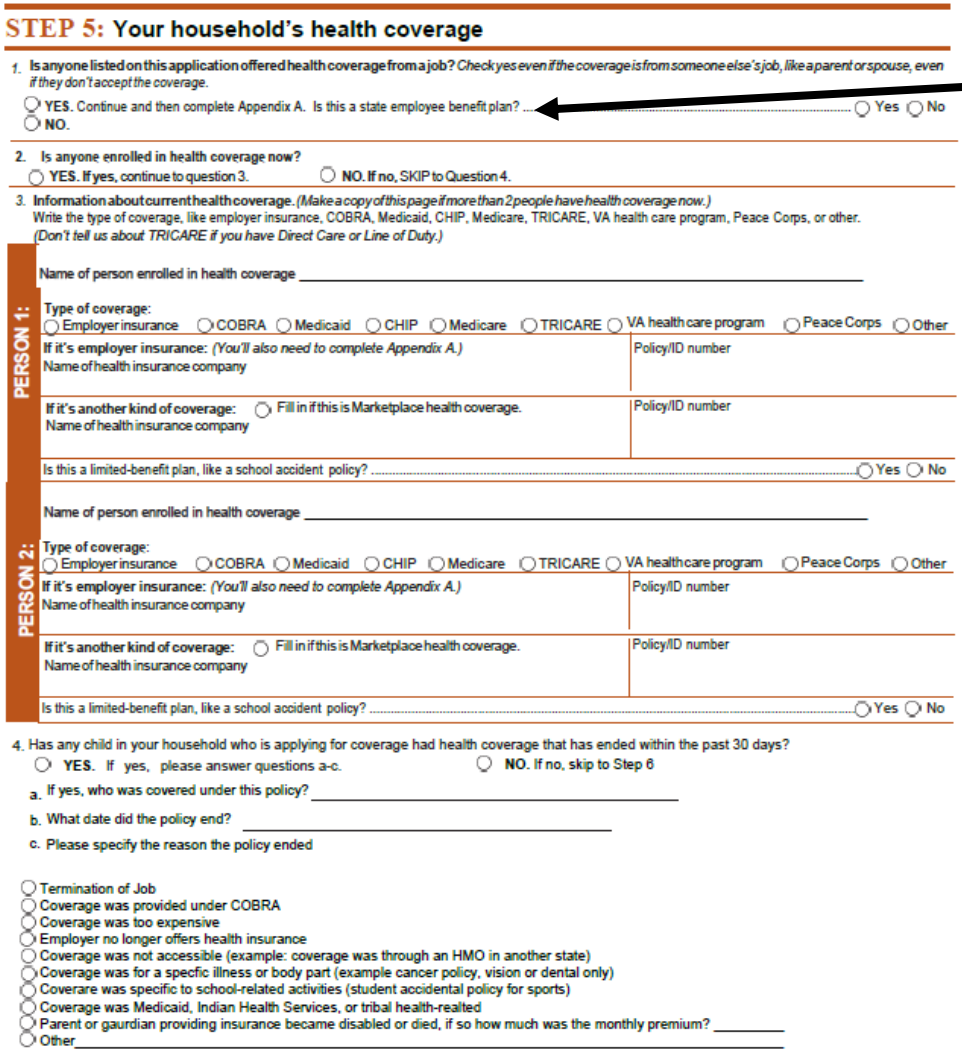
Application Step 5



STEP 5: Your household's health coverage

1. **Is anyone listed on this application offered health coverage from a job?** *Check yes even if the coverage is from someone else's job, like a parent or spouse, even if they don't accept the coverage.*

◯ **YES.** Continue and then complete Appendix A. Is this a state employee benefit plan? ..... ◯ Yes ◯ No
◯ **NO.**

2. **Is anyone enrolled in health coverage now?**
◯ **YES. If yes,** continue to question 3. ◯ **NO. If no,** SKIP to Question 4.

3. **Information about current health coverage.** *(Make a copy of this page if more than 2 people have health coverage now.)*
Write the type of coverage, like employer insurance, COBRA, Medicaid, CHIP, Medicare, TRICARE, VA health care program, Peace Corps, or other.
(Don't tell us about TRICARE if you have Direct Care or Line of Duty.)

PERSON 1:

Name of person enrolled in health coverage _____

Type of coverage:
◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE ◯ VA health care program ◯ Peace Corps ◯ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)*
Name of health insurance company | Policy/ID number

If it's another kind of coverage: ◯ Fill in if this is Marketplace health coverage.
Name of health insurance company | Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ..... ◯ Yes ◯ No

PERSON 2:

Name of person enrolled in health coverage _____

Type of coverage:
◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE ◯ VA health care program ◯ Peace Corps ◯ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)*
Name of health insurance company | Policy/ID number

If it's another kind of coverage: ◯ Fill in if this is Marketplace health coverage.
Name of health insurance company | Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ..... ◯ Yes ◯ No

4. Has any child in your household who is applying for coverage had health coverage that has ended within the past 30 days?
◯ **YES.** If yes, please answer questions a-c. ◯ **NO.** If no, skip to Step 6

a. If yes, who was covered under this policy? _____
b. What date did the policy end? _____
c. Please specify the reason the policy ended

◯ Termination of Job
◯ Coverage was provided under COBRA
◯ Coverage was too expensive
◯ Employer no longer offers health insurance
◯ Coverage was not accessible (example: coverage was through an HMO in another state)
◯ Coverage was for a specfic illness or body part (example cancer policy, vision or dental only)
◯ Coverare was specific to school-related activities (student accidental policy for sports)
◯ Coverage was Medicaid, Indian Health Services, or tribal health-realted
◯ Parent or gaurdian providing insurance became disabled or died, if so how much was the monthly premium? _____
◯ Other _____

Complete Appendix A if insured through an employer

Tell us about any other health coverage the household has.

- Employer insurance
- COBRA
- Medicaid
- CHIP
- Medicare
- TRICARE
- VA health care program
- Peace Corps
- Other, such as a Medicare supplement or prescription drug plan

Include a copy of both sides of all cards

Wyoming Department of Health

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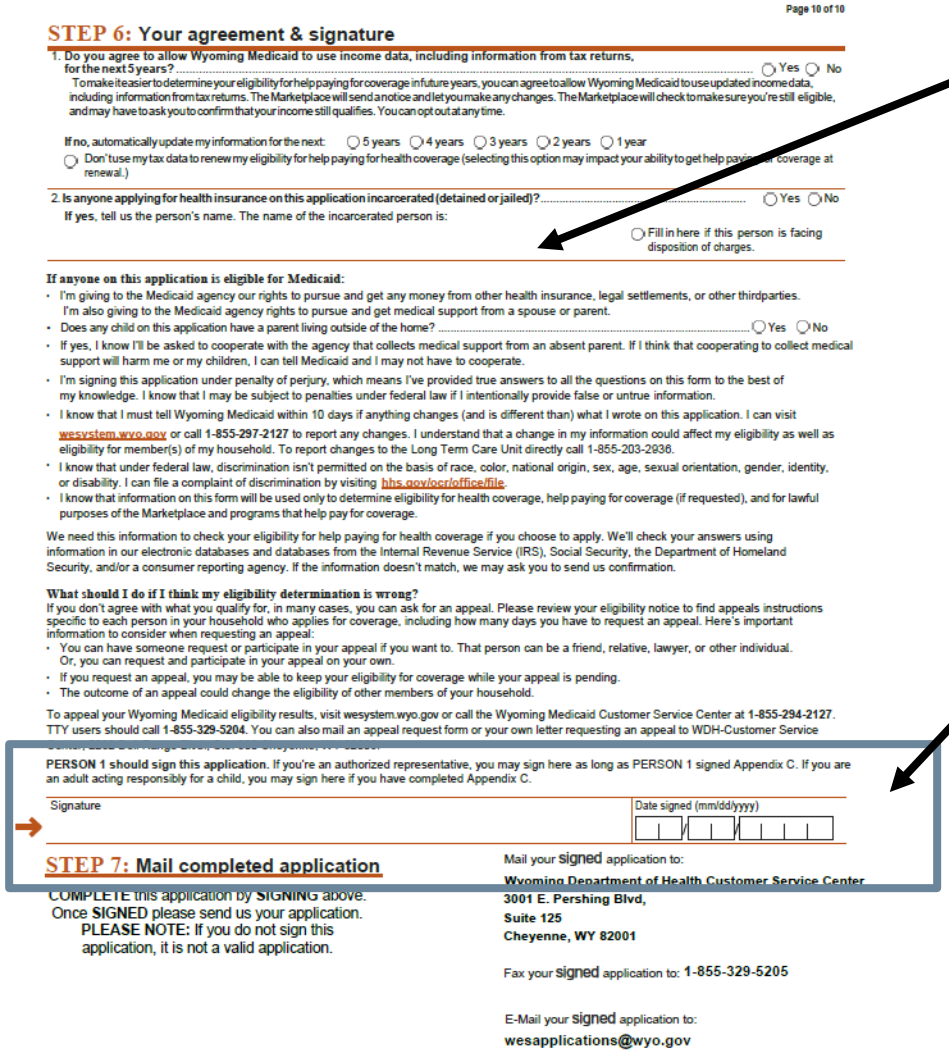
Application Step 6



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STEP 6: Your agreement & signature

1. **Do you agree to allow Wyoming Medicaid to use income data, including information from tax returns, for the next 5 years?** ..... ◯ Yes ◯ No

To make it easier to determine your eligibility for help paying for coverage in future years, you can agree to allow Wyoming Medicaid to use updated income data, including information from tax returns. The Marketplace will send a notice and let you make any changes. The Marketplace will check to make sure you're still eligible, and may have to ask you to confirm that your income still qualifies. You can opt out at any time.

If no, automatically update my information for the next: ◯ 5 years ◯ 4 years ◯ 3 years ◯ 2 years ◯ 1 year

◯ Don't use my tax data to renew my eligibility for help paying for health coverage (selecting this option may impact your ability to get help paying for coverage at renewal.)

2. **Is anyone applying for health insurance on this application incarcerated (detained or jailed)?** ..... ◯ Yes ◯ No

If yes, tell us the person's name. The name of the incarcerated person is:

◯ Fill in here if this person is facing disposition of charges.

If anyone on this application is eligible for Medicaid:

- I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ..... ◯ Yes ◯ No
- If yes, I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell Wyoming Medicaid within 10 days if anything changes (and is different than) what I wrote on this application. I can visit wesystem.wyo.gov or call **1-855-297-2127** to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household. To report changes to the Long Term Care Unit directly call 1-855-203-2936.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender, identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us confirmation.

What should I do if I think my eligibility determination is wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your Wyoming Medicaid eligibility results, visit wesystem.wyo.gov or call the Wyoming Medicaid Customer Service Center at **1-855-294-2127**. TTY users should call **1-855-329-5204**. You can also mail an appeal request form or your own letter requesting an appeal to WDH-Customer Service

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C. If you are an adult acting responsibly for a child, you may sign here if you have completed Appendix C.

Signature | Date signed (mm/dd/yyyy)

STEP 7: Mail completed application

COMPLETE this application by SIGNING above.
Once SIGNED please send us your application.
PLEASE NOTE: If you do not sign this application, it is not a valid application.

Mail your **signed** application to:
Wyoming Department of Health Customer Service Center
3001 E. Pershing Blvd,
Suite 125
Cheyenne, WY 82001

Fax your **signed** application to: **1-855-329-5205**

E-Mail your **signed** application to:
wesapplications@wyo.gov

Complete #2 only if the applicant is incarcerated

Sign and date the application

- Electronic signatures have to be an actual signature. Signatures cannot be typed in a cursive font.

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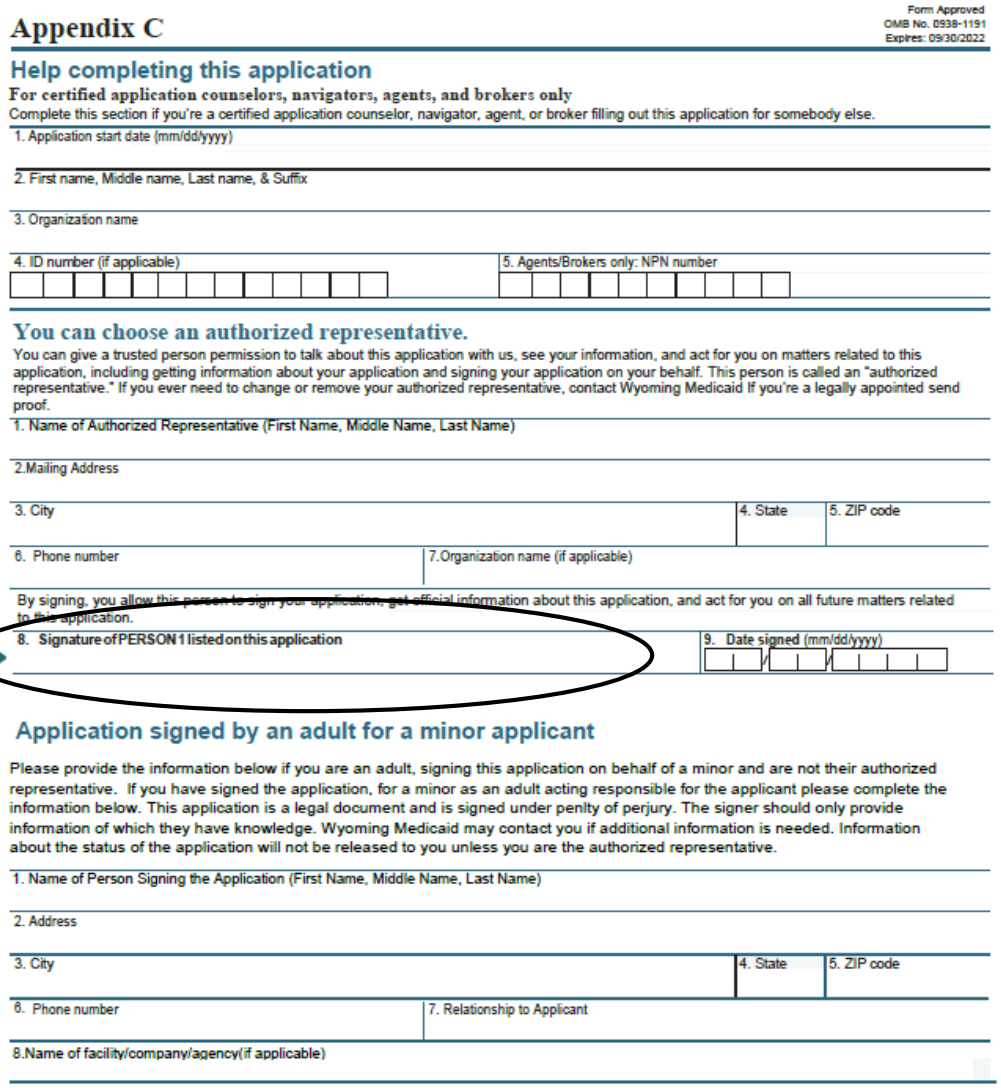
Application Appendix C



Appendix C

Form Approved
OMB No. 0938-1191
Expires: 09/30/2022

Help completing this application

For certified application counselors, navigators, agents, and brokers only

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change or remove your authorized representative, contact Wyoming Medicaid If you're a legally appointed send proof.

1. Name of Authorized Representative (First Name, Middle Name, Last Name)

2.Mailing Address

3. City | 4. State | 5. ZIP code

6. Phone number | 7.Organization name (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

8. Signature of PERSON 1 listed on this application | 9. Date signed (mm/dd/yyyy)

Application signed by an adult for a minor applicant

Please provide the information below if you are an adult, signing this application on behalf of a minor and are not their authorized representative. If you have signed the application, for a minor as an adult acting responsible for the applicant please complete the information below. This application is a legal document and is signed under penlty of perjury. The signer should only provide information of which they have knowledge. Wyoming Medicaid may contact you if additional information is needed. Information about the status of the application will not be released to you unless you are the authorized representative.

1. Name of Person Signing the Application (First Name, Middle Name, Last Name)

2. Address

3. City | 4. State | 5. ZIP code

6. Phone number | 7. Relationship to Applicant

8.Name of facility/company/agency(if applicable)

Authorized representative's information

Signature of the applicant, power of attorney (POA) or guardian. A copy of the POA document or court order is needed if signed by the POA or guardian.

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Application Appendix D

APPENDIX D

Additional Assistance for Aged, Blind, or Disabled Persons

You **DON'T** need to answer these questions unless someone in the household is applying for Medicaid coverage because they are aged, blind, disabled, or wanting help with paying their Medicare premiums.

Please read all questions carefully and complete each section to the best of your ability. If you have any questions, you may call the Wyoming Medicaid Customer Service Center at **1-855-294-2127**, or the Wyoming Medicaid Long Term Care Unit at **1-855-203-2936**

Estate Recovery

Before you apply, it is important that you know the State of Wyoming will pursue costs paid by Wyoming Medicaid from the estate of a Medicaid recipient, age 55 years or older or any age when a Medicaid recipient was an inpatient in a medical institution when they received medical assistance.

Tell us about who is applying.

	PERSON 1	PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Is this person currently receiving or entitled to Medicare?	☐ Yes ☐ No If yes, Medicare number:	☐ Yes ☐ No If yes, Medicare number:
3. Has this person been covered by long term care insurance that ended in the last three (3) months?	☐ Yes ☐ No If yes, date insurance ended: MM / DD / YYYY Reason insurance ended:	☐ Yes ☐ No If yes, date insurance ended: MM / DD / YYYY Reason insurance ended:
4. Is this person currently in a medical facility or long term care facility, or do they plan to live in a long term care facility?	☐ Yes ☐ No If yes, type of facility: ☐ Hospital ☐ Nursing Home ☐ Assisted Living Facility ☐ Other: ____ Name of Facility: Entry Date: MM / DD / YYYY	☐ Yes ☐ No If yes, type of facility: ☐ Hospital ☐ Nursing Home ☐ Assisted Living Facility ☐ Other: ____ Name of Facility: Entry Date: MM / DD / YYYY
5. Does this person require nursing home level of care but wish to remain in their home or require services based on a developmental disability?	☐ Yes ☐ No	☐ Yes ☐ No

If the applicant is requesting waiver services, indicate it here.

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Application Appendix D

	PERSON 1	PERSON 2
6. Does this person have a Companion or Care Contract in Place?	☐ Yes ☐ No	☐ Yes ☐ No
7. Has anyone in your household served in the Armed Forces?	☐ Yes ☐ No If yes, name of household member:	☐ Yes ☐ No If yes, name of household member:
8. Is this person the dependent of a veteran?	☐ Yes ☐ No If yes, relationship to veteran: ☐ Spouse ☐ Child ☐ Parent Name of Veteran: Veteran's claim number:	☐ Yes ☐ No If yes, relationship to veteran: ☐ Spouse ☐ Child ☐ Parent Name of Veteran: Veteran's claim number:
9. Does this person have any income not listed on the Health Coverage Application? Examples include VA income, worker's compensation monies, child support, etc.	☐ Yes ☐ No If yes, type of income: Monthly Amount: $	☐ Yes ☐ No If yes, type of income: Monthly Amount: $
10. Has this person received or are they expecting to receive a one-time payment, such as a settlement, inheritance, retroactive payment, etc.?	☐ Yes ☐ No If yes, please list the date: MM / DD / YYYY Amount: $	☐ Yes ☐ No If yes, please list the date: MM / DD / YYYY Amount: $
11. Does this person receive money as a gift on a monthly basis to pay expenses?	☐ Yes ☐ No If yes, name of person providing payment: Monthly Amount: $	☐ Yes ☐ No If yes, name of person providing payment: Monthly Amount: $
12. Has this person sold, transferred, traded, or given away any items of value in the past 60 months? Examples include trusts, real estate, automobiles, burial spaces, etc.	☐ Yes ☐ No If yes, please list the date: MM / DD / YYYY Item(s) sold,transferred, traded, or given away: Value: $ Amount received from transaction: $ Name of person who received the item:	☐ Yes ☐ No If yes, please list the date: MM / DD / YYYY Item(s) sold,transferred, traded, or given away: Value: $ Amount received from transaction: $ Name of person who received the item:

When a family member is being paid to provide care, applicant must have an executed care contract.

Annual payments from royalties or mineral rights

Examples include:
- Gifted a car to grandchild
- Sold a house, vehicle or recreational vehicle
- Cashed out a CD

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Application Appendix D

Tell us about resources belonging to household members

Type	Y	N	Household Member(s)	Amount	Financial Institution/ Company Name	Account Number
Cash on Hand						
Checking Account						
Checking Account						
Direct Express						
Savings Account						
Savings Account						
Able Account						
Credit Union Account						
Nursing Home Account						
Certificate of Deposit						
Stocks/Bonds/Annuities						
IRA/401K/Keogh/Pension Plan						
Burial Funds/Trusts						
Pooled Trust						
Special Needs Trust						
Any Other Trust						
Life Insurance						
Annuity						
Other Resources						

Please review each line with the applicant and mark an X on “Y” or “N” for EACH item

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Application Appendix D

Type	Y	N	Household Member(s)	Value
Automobile				
Automobile				
Automobile				
Automobile				
Recreational Vehicle				
Crops/Equipment				
Tractors				
Livestock				
Property/Real Estate				
Life Estate				
Burial Space				
Contract for Deed and/or Promissory Note				
Safety Deposit Box				
Other Resources				

Please review each line with the applicant and mark an X on “Y” or “N” for EACH item

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Resource Standards
Aged, Blind or Disabled Programs

- Resource Standards
  - $2,000 Individual
  - $3,000 Couple
  - $130,380 Spousal Resource Allowance
  - $3,259.50 Spousal Income Allowance

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Resource Verification Requirements

- Submit verification of all resources declared on the Medicaid application:
  - Complete statement showing balance as of the first of the month with transaction history, for the month of application.
    - Bank statements
    - Certificate of Deposits
    - Stocks and Bonds
  - Direct Express Card – balance as of the first of the month and transaction summary
    - Applicant or representative may call (888) 741-1115
      - Enter applicant's 16 digits card number or SSN, or stay on the line.
      - Automated phone system will connect caller to a Customer Service Agent from Direct Express.

Additional bank statements may be needed if the applicant sold, traded or transferred anything of value in the 60 months prior to application date

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Resource Verification Requirements

- Life Insurance
  - Verification of type of policy, face value, and current cash surrender value. The cash value of the policy will count when calculating the applicant's available resources. The applicant can opt to assign a policy to a funeral home, write a statement that the policy is to be used for funeral expenses, take loan against the cash value or surrender the policy as part of the spend down process.
- Annuity
  - Verification of contract to include the terms, value, and access.
- Burial Contracts
  - Verification from funeral home showing the goods and services and irrevocable assignment

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Resource Verification Requirements

- Trust
  - Complete copy, including schedule A showing current resources held by the trust and any resources disposed of in the past 60 months
- Vehicles
  - Include all vehicles whether or not they are currently registered. Applicant is allowed **ONE exempt vehicle** that is deemed necessary for transportation purposes.
- Recreational vehicles
  - To include but not limited to all motor homes, 5th wheels, trailers (RV and towing), boats, ATV's, snowmobiles, and motorcycles.
- Crops, equipment, tractors, livestock
  - If this is necessary for self employment, please include the most recent tax documentation or business ledger.
- Property
  - List all property owned by applicant and their spouse, if applicable

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Resource Verification Requirements

- Contract for deed or promissory note
  - Complete contract and payment history.
- Safety deposit box
  - Signed statement of contents. If items are of value, items need an appraisal. (e.g., coin collection)
- Mineral rights/ gas & oil royalties
  - Verification of income received for the past 30 days - annual statements will be accepted if statement is identified as an annual statement.
  - Current market value estimate from a knowledgeable source. Knowledgeable sources include:
    - Bureau of Land Management
    - US Geological Survey
    - A mining company that holds leases
    - Real estate brokers
    - Banks, savings and loan associations, mortgage companies and similar lending institutions

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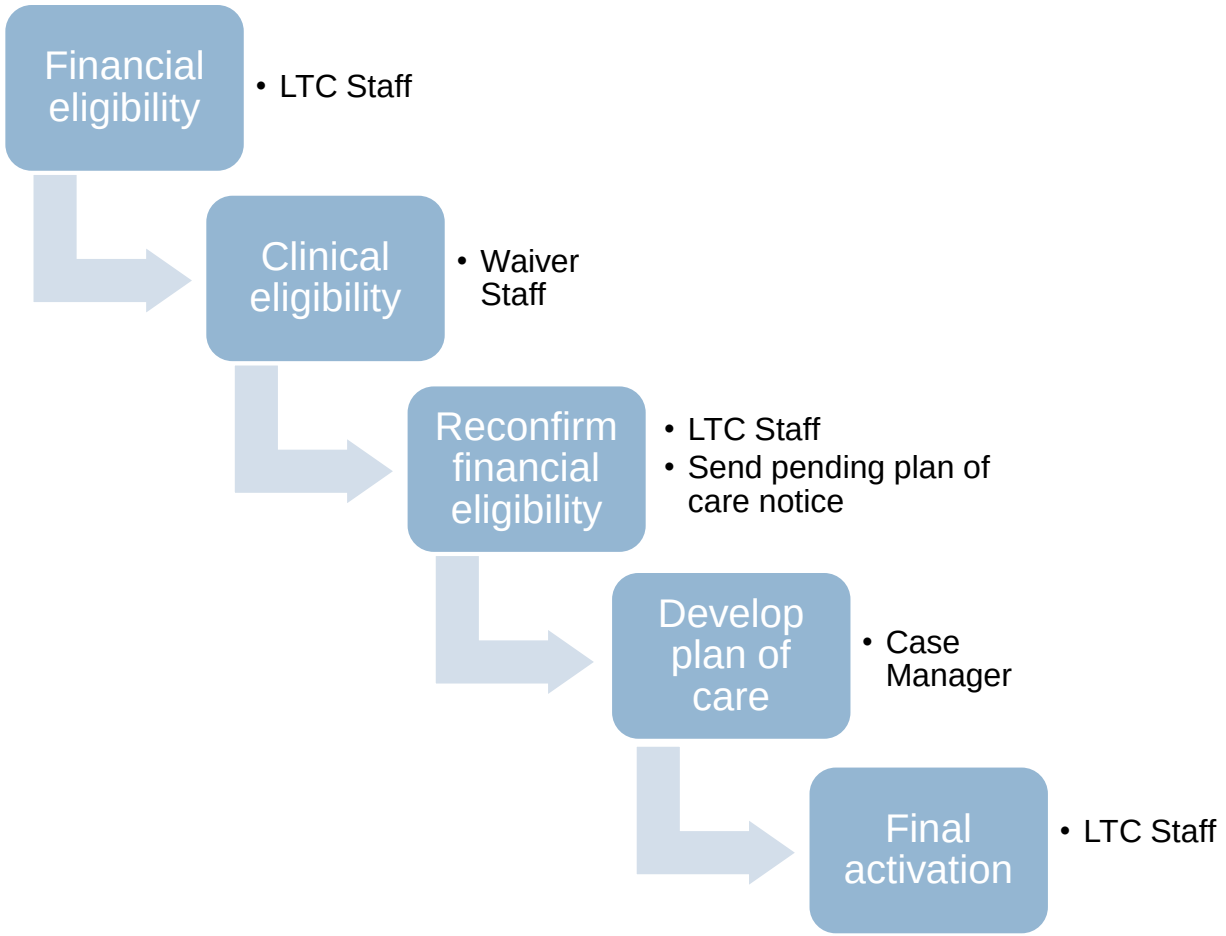
EMWS Eligibility Process Flow



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Additional Eligibility Requirements
Aged, Blind or Disabled

- Level of Care Determination (LT101)
  - Community Choices Home & Community Based Waiver
  - Nursing Home
- Hospice Election
  - Life Expectancy - 6 months or less
  - Hospice Election form and physician's statement are required.

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Additional Eligibility Requirements

- 30 day requirement
  - Nursing Home and Inpatient Hospital Care
    - Remain in an institution for 30 consecutive days
  - Hospice
    - Complete 30 days of institutionalization prior to Hospice election; or
    - Complete an election statement 30 days prior to authorization of benefits.

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Communication

- Initiate closure when the client:
  - Admits to a facility.
  - Moves. If the client leaves the state a forwarding address is helpful
  - Voluntarily leaves program. A written statement from client is required to close benefits during the PHE.
  - Client passes away.
  - Unable to contact the client.
  - No services within last 30 days.

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Thank You!

Questions?

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